MEDICAL HISTORY RECORD

All information is treated as confidential unless you grant permission to release it. **Please print and complete all information.**

Case No.	Medicare No.	Medicaid No.	Today's Date	Birth date	Male ☐ Female ☐
Last Name	First	Middle	Daytime phone	Home Phone	
Address	City	State Zip	Marital Status	Occupation	
Person to notify in emergency		Daytime Phone	Relationship	Last Physical Examination Date	
By Doctor		Phone	Family or Referring Doctor	Phone No.	
May I contact either of these Doctors for your past health records?	Yes ☐ No ☐	What are your present medical symptoms?			

Family History	IF LIVING Age	HEALTH Good Fair Poor	IF DECEASED Death Age	Death Cause
Father				
Mother				
Brothers (Circle Sisters Sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
Husband ☐ Wife ☐				
Sons (circle Daughters sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
6. M F				

Any blood relatives who have or have had any of the listed conditions

	✔ Yes	No	Relationship		✔ Yes	No	Relationship
Asthma				Hay Fever			
Arthritis				Insanity			
Allergies				Kidney Disease			
Anemia				Leukemia			
Alcoholism				Migraine			
Bleeding Tend.				Nervous Break'n			
Cancer				Obesity			
Colitis				Rheumatism			
Congenital Heart				Rheumatic Fever			
Diabetes				Stroke			
Epilepsy				Suicide			
Goiter				Stomach Ulcers			
High Bl. Press.				Tuberculosis			
Heart Disease							

HABITS

Do You	✔ Yes	No	Daily Consumption:
Smoke	☐	☐	Pkgs.
Drink Coffee	☐	☐	Cups
Drink Alcohol	☐	☐	oz.
Drink Beer	☐	☐	oz.
Fall Asleep Easily	☐	☐	
Awaken Early	☐	☐	

MEDICATIONS

✔ If Taken	✔		✔		✔	
Antacids	☐	Blood Thinning Pills	☐	Iron or Poor Blood Med.	☐	Vitamins ☐
Antibiotics	☐	Cortisone	☐	Laxatives	☐	Water Pills ☐
Aspirin, Bufferin, Anacin	☐	Cough Medicine	☐	Phenobarbital	☐	Weight Reducing Pills ☐
Barbiturates	☐	Digitalis	☐	Shots	☐	Other (list)
Birth Control Pills	☐	Dilantin	☐	Sleeping Pills	☐	
Blood Pressure Pills	☐	Hormones	☐	Thyroid Med.	☐	
		Insulin, Diabetic Pills	☐	Tranquilizers	☐	

Operations you have had:	Year	Diseases you have had requiring hospitalization	Year	Serious illness not requiring hospitalization	Year

Drugs you are allergic to:

Describe any serious injuries or accidents you have had

WOMEN only:

	✔ Yes	No	
Are you still having regular monthly menstrual periods?	☐	☐	
Have you ever had bleeding between your periods?	☐	☐	When?
Do you have very heavy bleeding with your periods?	☐	☐	When?
Do you feel bloated and irritable before your period?	☐	☐	
Are you now on or have you ever taken the birth control pill?	☐	☐	When?
Have you ever had a miscarriage?	☐	☐	When?
Have you ever had a discharge from the nipple of your breast?	☐	☐	When?
Do you regularly have the cancer test of the cervix?	☐	☐	Date of last test

How many children born alive ____
How many stillbirths ____
How many premature births ____
Date of last menstrual period ____
How many miscarriages ____
How many cesarean operations ____
Any complications of pregnancy? (explain) ____

MEN only: Have you ever had:

	✔ Yes	No
Loss of sexual activity? For how long?	☐	☐
Treatment for genitals (private parts)?	☐	☐
Discharge from penis?	☐	☐
Hernia (rupture)?	☐	☐
Prostate trouble?	☐	☐

MEN and WOMEN:

	✔ Yes	No
Do you frequently have severe headaches	☐	☐
(If yes, answer the following):		
Do they cause visual trouble?	☐	☐
Do they occur on one side of the head?	☐	☐
Do they awaken you at night?	☐	☐
Do they feel like a tight hat band?	☐	☐
Do they hurt most in the back of the head and neck?	☐	☐
Does aspirin relieve them?	☐	☐

	✔ Yes	No
Have you ever fainted?	☐	☐
Spells of dizziness?	☐	☐
Spells of weakness of arm or leg?	☐	☐
Ringing in ears?	☐	☐
Have you ever had a convulsion?	☐	☐
Double vision?	☐	☐
Pains in ear?	☐	☐
Nosebleeds?	☐	☐

Have you recently had pain in the stomach which:

	✔ Yes	N
Occurs 1-2 hours after a meal?	☐	
Is brought on by eating fried foods, gassy foods?	☐	
Awakens you at night?	☐	
Is relieved by antacid medications?	☐	
Is relieved with milk or eating?	☐	
Occurs while eating or immediately after?	☐	
Is relieved by a bowel movement?	☐	
Causes loss of appetite?	☐	

Do you frequently have:

	✔ Yes	No
Bleeding gums?	☐	☐
Trouble swallowing?	☐	☐
Hoarseness?	☐	☐
A sore tongue?	☐	☐
Nausea and vomiting?	☐	☐

Have you ever had shortness of breath?

	✔ Yes	No
Doing your usual work?	☐	☐
Climbing a flight of stairs?	☐	☐
Which awakens you at night?	☐	☐
Do you have a chronic cough?	☐	☐
Which causes you to cough?	☐	☐
Accompanied by wheezing?	☐	☐
Have you ever coughed blood?	☐	☐
Do you cough up much sputum?	☐	☐

Have you had pain or tightness in the chest which begins:

	✔ Yes	No
When exerting yourself?	☐	☐
When walking against a wind?	☐	☐
When walking up a hill?	☐	☐
After a heavy meal?	☐	☐
When upset or excited?	☐	☐
Palpitations	☐	☐
Do you sleep on more than one pillow?	☐	☐
Radiates down the arm?	☐	☐
Disappears if you rest?	☐	☐
Occurs only at rest?	☐	☐
When walking fast?	☐	☐
When walking in cold weather?	☐	☐

If you have chest pain or tightness please explain

Have you had?	✔ Yes	No	When or since when?
Burning when urinating?	☐	☐	
Loss of control of bladder?	☐	☐	
Blood in the urine?	☐	☐	
Dark colored urine?	☐	☐	
Trouble starting to urinate?	☐	☐	
Trouble holding the urine?	☐	☐	
To get up frequently at night?	☐	☐	
Passed a kidney stone?	☐	☐	

Have you recently had:	✔ Yes	No	When or since when?
Pains in calves of legs when walking?	☐	☐	
Cramps in legs at night?	☐	☐	
Pain in the big toe?	☐	☐	
Varicose veins?	☐	☐	
Phlebitis or inflamed leg veins?	☐	☐	
Swelling in the ankles	☐	☐	

If you have had a change in bowel habit recently answer the following:	✔ Yes	No	When or since when?
Crampy pain in abdomen?	☐	☐	
Alternating diarrhea and constipation?	☐	☐	
Pain during or after bowel movement?	☐	☐	
Mucous in the stool?	☐	☐	
Blood in the stool?	☐	☐	
Ribbon like stools?	☐	☐	
Black stools?	☐	☐	
Require use of strong laxatives or enemas?	☐	☐	
	☐	☐	

Describe briefly your present medical symptoms and anything else we should know about your health.

NAME:

DATE:

Include how you feel today AND during the previous twelve months for all questions.

PART A

	Never	Rarely	Some-times	Often	Very Often
1. How often do you feel energetic and healthy?	①	②	③	④	⑤
2. Is your complexion and skin smooth, lustrous and healthy?	①	②	③	④	⑤
3. Is your hair healthy and shiny?	①	②	③	④	⑤
4. Do you have a good appetite?	①	②	③	④	⑤
5. Are you sleeping well at night and feel rested upon waking?	①	②	③	④	⑤
6. How often do you feel positive and optimistic?	①	②	③	④	⑤
7. In social situations do you feel energetic and confident?	①	②	③	④	⑤

PART B

8. Do you have a weak voice when speaking?	①	②	③	④	⑤
9. Do you ever experience shortness of breath?	①	②	③	④	⑤
10. How often are you fatigued and have low energy?	①	②	③	④	⑤
11. Do you sweat easily even with minor exertion?	①	②	③	④	⑤
12. Is your complexion pale?	①	②	③	④	⑤
13. How often do you catch colds?	①	②	③	④	⑤
14. Do you prefer a quiet environment with less talking?	①	②	③	④	⑤
15. Are you so short of breath that speaking is difficult?	①	②	③	④	⑤

PART C

16. How often do you feel cold and wear warmer clothes than others?	①	②	③	④	⑤
17. Do you dislike air conditioned rooms and winter weather?	①	②	③	④	⑤
18. Does eating cold foods cause you discomfort?	①	②	③	④	⑤
19. Is the tip of your nose noticeably cold and pale in color?	①	②	③	④	⑤
20. Does cold weather cause low back discomfort?	①	②	③	④	⑤
21. Are your extremities cold?	①	②	③	④	⑤
22. Are you overweight, even slightly?	①	②	③	④	⑤
23. Do you wake up at night to urinate?	①	②	③	④	⑤

PART D

24. Do your hands and feet get hot and feel like they are burning?	①	②	③	④	⑤
25. Are you easily angered or irritated?	①	②	③	④	⑤
26. Are you underweight?	①	②	③	④	⑤
27. Does your face or cheeks get flushed and red?	①	②	③	④	⑤
28. Are you constipated or have difficult dry bowel movements?	①	②	③	④	⑤
29. How often is your throat dry and parched?	①	②	③	④	⑤
30. How often do you have an overall feeling of being hot?	①	②	③	④	⑤
31. How often are your eyes dry?	①	②	③	④	⑤

PART E

32. Do you have bruises or bleeding under the skin?	①	②	③	④	⑤
33. Is your complexion/skin-tone unusually dark or pigmented?	①	②	③	④	⑤
34. Do you have spider veins or veins seen through the skin?	①	②	③	④	⑤
35. Do you have stabbing pain that typically stays in one place?	①	②	③	④	⑤
36. Do you have dry and scaly skin?	①	②	③	④	⑤
37. How often are your lips purple?	①	②	③	④	⑤
38. How often do you have dark circles under your eyes?	①	②	③	④	⑤
39. How often are you forgetful?	①	②	③	④	⑤

Include how you feel today AND during the previous twelve months for all questions.

PART F

	Never	Rarely	Some-times	Often	Very Often
40. Do you have an oily complexion?	①	②	③	④	⑤
41. Is there a thick coating on your tongue?	①	②	③	④	⑤
42. Do you have a soft, spongy belly?	①	②	③	④	⑤
43. Is you sweat sticky or oily?	①	②	③	④	⑤
44. How often do you feel heavy, slow and sluggish?	①	②	③	④	⑤
45. How often does your nose run or you have a cough with phlegm?	①	②	③	④	⑤
46. Does your mouth feel sticky and greasy?	①	②	③	④	⑤
47. Do you have fatty bumps under your skin?	①	②	③	④	⑤

PART G

48. Do you tend to have an oily complexion?	①	②	③	④	⑤
49. Do you have acne or get skin eruptions?	①	②	③	④	⑤
50. Do you get a bitter taste in your mouth?	①	②	③	④	⑤
51. Do you have a yellowish vaginal discharge (females) or an increased amount of moisture around the genitals (male)?	①	②	③	④	⑤
52. How often is your urine dark and hot when expelling it?	①	②	③	④	⑤
53. Do you get canker sores on your lips or mouth?	①	②	③	④	⑤
54. Are you irritable or hot-tempered?	①	②	③	④	⑤
55. How often are your bowel movements loose and smelly?	①	②	③	④	⑤

PART H

56. How often are you depressed?	①	②	③	④	⑤
57. How often do you feel stressed out and anxious?	①	②	③	④	⑤
58. Is sadness something that happens easily to you?	①	②	③	④	⑤
59. Do you feel like sighing?	①	②	③	④	⑤
60. Does it feel like something is stuck in your throat?	①	②	③	④	⑤
61. Are you easily frightened?	①	②	③	④	⑤
62. Do you worry a lot about too many things?	①	②	③	④	⑤
63. Do you feel a heavy feeling around your ribcage or breast area?	①	②	③	④	⑤

PART I

64. Does your skin get red after you briefly scratch it?	①	②	③	④	⑤
65. How often do you have allergic problems?	①	②	③	④	⑤
66. How often do you have sinus congestion?	①	②	③	④	⑤
67. Do you sneeze often even if you don't have a cold?	①	②	③	④	⑤
68. Is your nose runny when you don't have a cold?	①	②	③	④	⑤
69. How often do you have skin rashes?	①	②	③	④	⑤
70. Do you have purplish (not red) spots or patches on your skin?	①	②	③	④	⑤
71. How often do you wheeze or have asthmatic problems?	①	②	③	④	⑤

PART J

72. Is your complexion/skin pale and dry?	①	②	③	④	⑤
73. Are your lips dry or your fingernails brittle?	①	②	③	④	⑤
74. Do you get dizzy when standing up from a sitting position?	①	②	③	④	⑤
75. Do you forget where you leave items?	①	②	③	④	⑤
76. Is your hair dry, dull, or breaking off?	①	②	③	④	⑤
77. How often do your hands and/or feet get numb?	①	②	③	④	⑤
78. How often do you feel your heart beating too strong?	①	②	③	④	⑤
79. How often are your eyes dry?	①	②	③	④	⑤

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

PATIENT NAME:

ACUPUNCTURIST NAME: Wendy Blewett L.Ac.

(Date)

PATIENT SIGNATURE: X

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

A2005

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) and provide National Arbitration and Mediation ("NAM") with the party arbitrator's contact information within thirty days of the date Respondent files its initial responsive pleading. A third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties from a list of arbitrators supplied by National Arbitration and Mediation ("NAM") within thirty days thereafter. The list supplied by NAM shall be a list of between 5 and 10 arbitrators, depending upon availability. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that, where not in conflict with this agreement, the Healthcare Malpractice Dispute Resolution Rules and Procedures of NAM shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of NAM rules are available on its website at https://www.namadr.com or by calling 1-800-358-2550 to request a copy of the rules.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the healthcare provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE